TRICARE PRIME ENROLLMENT/CHANGE APPLICATION

- New Enrollment
- Transfer from Region _____
- Other Health Insurance Information
- Change PCM
- Update Address
- Disenroll

ACTIVE DUTY SERVICE MEMBER INFORMATION — MUST COMPLETE FULLY TO PROCESS ENROLLMENT REQUEST

1) LAST NAME	FIRST NAME	MIDDLE INITIAL	2) SOCIAL SECURITY NUMBER

3) LOCAL MAILING ADDRESS	CITY	STATE	ZIP	4) FLYING STATUS (Job Related)
				YES NO

5) GENDER	6) DATE OF BIRTH	7) HOME PHONE	DUTY PHONE (MANDATORY)	8) BRANCH OF SERVICE	CIRCLE ONE:
M F				Army Navy Air Force Marines	Coast Guard

9) DEROS/ROTATION DATE	10) RANK	11) DUTY STATION/ASSIGNED UNIT & ADDRESS	12) PRIMARY CARE MANAGER (PCM)

FAMILY MEMBERS REQUESTING ENROLLMENT IN TRICARE PACIFIC (**DO NOT LIST MBRS NOT PHYSICALLY WITH YOU**)

1) LAST NAME	FIRST	MIDDLE INITIAL	RELATION TO AD MEMBER	DATE OF BIRTH
			SPOUSE DAUGHTER SON	MO DAY YEAR

SOCIAL SECURITY NUMBER	REQUESTED PRIMARY CARE MANAGER (PCM)	DATE

2) LAST NAME	FIRST	MIDDLE INITIAL	RELATION TO AD MEMBER	DATE OF BIRTH
			SPOUSE DAUGHTER SON	MO DAY YEAR

SOCIAL SECURITY NUMBER	REQUESTED PRIMARY CARE MANAGER (PCM)	DATE

3) LAST NAME	FIRST	MIDDLE INITIAL	RELATION TO AD MEMBER	DATE OF BIRTH
			SPOUSE DAUGHTER SON	MO DAY YEAR

SOCIAL SECURITY NUMBER	REQUESTED PRIMARY CARE MANAGER (PCM)	DATE

4) LAST NAME	FIRST	MIDDLE INITIAL	RELATION TO AD MEMBER	DATE OF BIRTH
			SPOUSE DAUGHTER SON	MO DAY YEAR

SOCIAL SECURITY NUMBER	REQUESTED PRIMARY CARE MANAGER (PCM)	DATE

5) LAST NAME	FIRST	MIDDLE INITIAL	RELATION TO AD MEMBER	DATE OF BIRTH
			SPOUSE DAUGHTER SON	MO DAY YEAR

SOCIAL SECURITY NUMBER	REQUESTED PRIMARY CARE MANAGER (PCM)	DATE

OTHER HEALTH INSURANCE (OHI)

DO YOU, OR ANY MEMBER OF YOUR FAMILY LISTED ABOVE, HAVE OHI? YES NO

IF YES, PLEASE CONTACT THE HBA OR BILLING DEPARTMENT AT YOUR FACILITY TO UPDATE YOUR BILLING INFORMATION

PLEASE INITIAL EACH STATEMENT AND SIGN BELOW

_____ I understand that enrollment into TRICARE Prime is contingent upon confirmation through the Defense Enrollment Eligibility Reporting System (DEERS).

_____ I understand that, except for emergencies, all TRICARE Prime services must be coordinated through the PCM. Normally, specialty and inpatient care is provided at an MTF. When not available at the MTF, specialty and inpatient care will be obtained through a civilian provider. If care is obtained that has not been coordinated by the PCM and authorized, I understand that I will be responsible for payment of charges in accordance with the provisions of the Point-of-Service option as described in the TRICARE "Your Military Health Plan" booklet and TRICARE regulations.

_____ I understand that if I allow my military identification card to expire, I will be automatically disenrolled from TRICARE Prime and will need to complete a new enrollment application, upon receipt of new ID, if continued enrollment is desired.

_____ I hereby certify that the information provided on this document is true and complete. I agree to abide by the provisions of membership in TRICARE

Signature	Relationship to Sponsor	Date

TRICARE PRIME ENROLLMENT/CHANGE APPLICATION

TRICARE Pacific

TRICARE Pacific

REQUEST TO CHANGE THE PRIMARY CARE MANAGER (PCM) FOR THE FOLLOWING MEMBER(S):

NAME	DATE OF BIRTH	REQUESTED PCM	EFFECTIVE DATE	REASON FOR REQUEST
1)				☐ DISSATISFIED WITH PROVIDER
2)				☐ ALL FAMILY MBRS TOGETHER
3)				☐ OTHER (EXPLAIN ATTACHED)

APPROVED / DISAPPROVED | SIGNATURE: _____ | DATE:_____

UPDATE ADDRESS FOR THE FOLLOWING MEMBER(S):

NEW ADDRESS	NEW PHONE # HOME	DUTY

NAME	DATE OF BIRTH	EFFECTIVE DATE
1)		
2)		
3)		

DISENROLL THE FOLLOWING FAMILY MEMBER(S):

NAME	DATE OF BIRTH	EFFECTIVE DATE	REASON FOR DISENROLLMENT
1)			☐ PCS TO NON-PRIME AREA
2)			☐ MEMBER HAS OHI
3)			☐ DEATH OF ENROLLEE
4)			☐ OTHER (EXPLAIN ATTACHED)

APPROVED / DISAPPROVED | SIGNATURE: _____ | DATE:_____

_____ I understand that if I choose to re-enroll, I must come to the TRICARE office and request such in writing.

Signature	Relationship to Sponsor	Date

(1) AUTHORITY: 5 USC 552a, 10 USC 1079 and 1086, 58 FR 45318. (2) PURPOSE: To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR, Part 199.71). (3) USES: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made on the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) DISCLOSURE: Voluntary; however, failure to provide information will result in our inability to process this request.

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